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AUTHOR Glicksman, Allen
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ABSTRACT

This research examined the relationship between ethnicity and the psychological status and behavior of Jewish and non-Jewish caregivers in relation to the impaired elderly. It was hypothesized that Jewish caregivers would make significantly more use of formal services than non-Jewish (usually Christian) caregivers. Two separate data sets were analyzed. The first study, "Senile Dementia Patients: Mental Health of Caregivers," had 239 subjects with complete information from the variables used in the analyses: clinical depression (to measure caregiver's psychological well-being) and the use of formal services (to measure caregiver's behavior). The second study, "Caring for Spouses with Alzheimer's Disease or Related Disorders: Crisis vs. Adaptation," had 228 subjects with complete information on all variables needed. Hierarchical stepwise regressions were completed with the ethnicity measure entering after all the other independent variables had entered the equation. Results showed that while ethnicity remained a significant predictor of behavior after controlling for the major correlates of the use of formal services, it was no longer a significant predictor of psychological status after controlling for the same independent variables. Discussion focuses on the role of ethnic heritage in determining attitudes toward suffering and willingness to use formal services. (TE)

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CAREGIVING AND ETHNICITY

Allen Glicksman
Philadelphia Geriatric Center

Introduction

While there is an expanding literature on ethnicity and aging, there has been little research on the relation between caregiving for the impaired elderly and ethnicity. We should expect such a relation to exist. After all, it is within the family that ethnicity is most salient and caregiving is usually a family affair.

This research is designed to further examine the relation between ethnicity and caregiving by asking the following question: When controlling for the major correlates of the psychological status and behavior of caregivers, does ethnicity remain a significant predictor of these dimensions?

Subjects

To test this hypothesis, analyses were completed using two data sets collected as part of research projects designed to examine caregiving. The first study, Senile Dementia Patients: Mental Health of Caregivers (NIMH Grant MH-37292) had 239 subjects with complete information for the variables used in the analyses. The second stucy, Caring for Spouses with Alzheimer's Disease or Related Disorders: Crisis Vs. Adaptation (NIMH Grant MH-40480) had 228 subjects with complete information on all variables needed. In both studies data was collected from respondents at several different times. For this research, the baseline data from both projects was used.

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Measures

Several dimensions of the psychological well-being and behavior of caregivers could be considered for analysis. The two areas selected for this study were clinical depression (to measure caregiver's psychological well-being) and the use of formal services (to measure caregiver's behavior). These dimensions were selected for several reasons. Since clinical depression is always an issue of concern when examining the lives of caregivers, the effect ethnicity might have on depression is a significant issue and so clinical depression was selected. Further, since the ethnic group to be examined here (Jewish caregivers) has shown consistently lower scores on scales of morale it seemed interesting to see if this correlation extended to depression. There was a methodological issue as well - both samples used the same depression scale (the CES-D), which made comparison of results much easier.

The variable used to operationalize the dimension of caregiving behavior was the number of formal services used by the caregiver. The willingness and ability to use formal services are indicators not only of certain social and psychological qualities of the caregiver as well as the ability of the caregiver to mobilize (and sometimes pay) for these resources, but in the case of willingness is most likely a measure of the ethnic/religious background of the caregiver as well. It seems probable that in an ethnic/religious tradition which places a strong emphasis on the alleviation of pain and suffering, rather than seeing the pain and suffering as a test from a "Higher

Authority," there will be more frequent use of such services. Judaism is a religious tradition which has never assigned the same meaning to suffering as Christianity. For that reason it is hypothesized that there will be significantly more use of formal services by Jewish than non-Jewish (usually Christian) caregivers and that the significance of this relationship will not be lost when controlling for the major predictors of the use of formal services.

The variables selected to measure the major correlates of caregiver psychological status and behavior were the gender, income and education of the caregiver, whether the caregiver worked or not, a health measure of the caregiver, and an ADL scale score for the impaired person. In addition, the first study, Senile Dementia Patients, also contained information on the relationship of the caregiver to the impaired person and whether the caregiver lived with the impaired person, and were therefore added to the analysis. In the second study, Caring for Spouses, all the caregivers were spouses and lived with the impaired person. Two sets of regressions were completed with the Senile Dementia Patients data set, one that included the relation to impaired person and living arrangements variables and one that only included the variables available in both data sets. To measure ethnicity a dummy variable was constructed asking if the respondent was Jewish or not. In the Senile Dementia Study, 94 (39% of total) were Jewish.

Results

In the zero-order correlations, the ethnicity variable correlated with both the CES-D scores ($p \leq .05$) and the index of number of formal services ($p \leq .05$) in both studies. Therefore, being Jewish was correlated with both caregiver psychological well-being and caregiver behavior as measured by these items.

Hierarchical stepwise regressions were completed with the ethnicity measure entering after all the other independent variables had entered the equation. When controlling for the independent variables listed above, ethnicity was no longer a significant predictor of CES-D scores in any of the regressions (sig of $F > .05$).

However, ethnicity remained a significant predictor of the number of formal services used ($p \leq .05$) in the regressions. In all the regressions where the number of formal services used was the dependent variable, the most significant predictor of use of formal services was the ADL score. In the Caregiving Spouses study, the next most significant predictor was income followed by ethnicity and the sex of the caregiver. No other independent variable was a significant predictor of use of formal services. In the regressions on the data from the Senile Dementia study, the most significant predictor of the use of formal services was the score on the ADL scale, followed by whether or not the caregiver lived with the impaired person, and then by ethnicity. When this regression was repeated using only the variables available in the Caregiving Spouse study, the significant predictors were ADL score and ethnicity. The strong influence of

the living arrangements (if the caregiver lived with the impaired person or not) is very interesting because of all the variables in the analysis, living arrangements is the most highly (and negatively) correlated with the ethnicity variable. That is, Jewish caregivers were significantly less likely to live with the impaired person than non-Jewish caregivers. This is in line with other research which indicates that three generation households are less common in American Jewish families than in either non-Jewish families in the United States or in Jewish families on other countries. This need to separate is an important part of the psycho-dynamics of American Jewish families, a subject which cannot be addressed in full at this time. However, we can observe that mobility is cardinal virtue of American Jewry, with both middle aged adult and older populations more mobile than their non-Jewish counterparts.

These regressions were then repeated using only white respondents. Ethnicity remained a significant predictor of the use of formal services but not a significant predictor of CES-D scores. The only change from the regressions using the entire samples was in the regressions on the Senile Dementia data, where income became a significant predictor of number of formal services used (but was a less significant predictor than ethnicity). It is possible that in the previous analyses race was suppressing the effect of income.

Discussion

Based on these analyses, we can say that while ethnicity remained a significant predictor of behavior even after controlling for the major correlates of the use of formal services, it was no longer a significant predictor of psychological status after controlling for the same independent variables.

This also confirms the hypothesis that ethnic background continues to significantly contribute to the prediction of caregiving behavior after taking such factors as adl level of the caregiver and income into account. How an individual will respond to the realities around them, such as the level of impairment is conditioned not only by a "rational" response to the situation but also by the value system in which the caregiver was raised. The choice whether to seek formal services or not is in part determined by what behavior people believe is appropriate in a given situation - the situation does not "speak" to the individual presenting one, obvious choice. In this particular case, Jewish civilization has always placed a special emphasis on the relief of pain and suffering, and has never assigned the ennobling or redemptive value to it that one finds in Christianity and especially in Catholicism. Even when the individual in question feels remote from a formal identification with religious tradition, values learned at home which originated in a religious tradition become part of their worldview, values which the individual might feel are "natural" ways of understanding the world. This research reemphasizes the need for

understanding all ethnic backgrounds, including the rich diversity subsumed under the category "white," to understand both religious and cultural identity and their effect throughout the life span.

Now a word on why the CES-D scores did not continue to be significantly related to ethnicity when controlling for other factors. In general, the correlations between ethnicity and CES-D was the weakest of all the significant correlations with CES-D. We have argued elsewhere that psychological well-being as defined through some of the standard scales of morale is correlated with ethnic background because many of the questions on such scales elicit routinized responses which are reflections of cultural values. To some extent, the CES-D scale asks similar questions as such standard morale scales as the Philadelphia Geriatric Center Morale Scale and the Bradburn Affect Balance Scale, and for this reason perhaps there is a correlation between ethnicity and CES-D scores. To the extent however that the CES-D is measuring something very different than the morale scales, there is no reason that the score should correlate with ethnicity, and the fact that ethnicity contributes nothing after accounting for the other predictors of depression seems to confirm that idea. Perhaps while morale is affected by ethnic style, depression is not. This points to the need for further refinement in the study of affect, ethnicity and aging.

In sum, we have seen that ethnicity is an important factor in attempting to understand the behavior of caregivers. It is a central element in understanding the behavior of individuals over the life span as well.